September 10, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-1014-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedic Surgery.

The physician reviewer AGREES with the determination of the insurance carrier. The reviewer is of the opinion that a lumbar diskogram is not medically necessary in this case.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 10th day of September 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___, 1601 Rio Grande, Suite 420, Austin, Texas 78701. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1014-01, in the area of Orthopedics. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. EMG done 8/02/01 which showed evidence consistent with chronic right S-1 nerve root irritation.
2. MRI, which showed at the L4-5 level a broad 2.0 mm annular disk bulge pressing against the anterior thecal sac; at the L5-S1 level, there is a posterior central 3.0 mm diskal protrusion pressing on the anterior aspect of the S-1 nerve root bilaterally and abutting the anterior thecal sac at the midline.
3. Face sheet.
4. Medical Dispute Resolution Request.
5. Letter of denial from Travelers.
6. ___ request for the diskogram, and some of his progress notes. I do not have the original workup.

B. BRIEF CLINICAL HISTORY:

This patient sustained a slip and fall on ___. According to the medical records that I have, the patient did not get an epidural steroid injection (ESI). He has had chronic low back pain that interferes with his work and his lifestyle. He has tried all conservative means including a back brace, anti-inflammatories, physical therapy, rehabilitation, i.e., general conservative back care.

C. DISPUTED SERVICES:

Lumbar diskogram.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. THIS TEST IS NOT MEDICALLY INDICATED, AS THERE ARE NOT ENOUGH MEDICAL FINDINGS TO SUPPORT IT.

E. RATIONALE OR BASIS FOR DECISION:

1. The results of diskograms are equivocal. When one reviews the literature, one cannot determine whether they are valid or not. It depends on whom one reads.

2. The patient has a negative exam.

3. To quote ___, the "mental status of the patient is expected to interfere" with his recovery.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 3 September 2002